CMS Manual System

Pub. 100-06 Medicare Financial Management

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 57 **Date: OCTOBER 22, 2004**

CHANGE REQUEST 3472

SUBJECT: Revised Reporting Requirements for Contractor Reporting of Operational Workload Data (CROWD) Health Professional Shortage Area (HPSA) Quarterly Report (CMS Form-1565E, CROWD Form S)

I. SUMMARY OF CHANGES: Section 413b of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) requires that for zip codes that fully fall into areas designated as a HPSA, the HPSA bonus payment be automatically paid. As a result of these changes to the HPSA bonus payment program, revisions have been made to reflect the method in which CROWD Form S data is reported.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: April 1, 2005
IMPLEMENTATION DATE: April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	6/290/Completing Health Professional Shortage Area (HPSA) Quarterly Report, Form CMS-1565E-General
R	6/290.2/Checking Reports
R	6/290.3/Current Quarter Payments
R	6/290.6/Error Descriptions

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

290 - Completing Health Professional Shortage Area (HPSA) Quarterly Report, Form CMS-1565E - General

(Rev. 57, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

The carriers prepare and submit to CMS each quarter a report on information regarding incentive payments made to physicians who render covered Medicare services in rural or urban HPSA (*see Pub. 100-04, Chapter 12, §§90.4 – 90.4.7*) on the results of its review of sample claims for HPSA incentive payments processed during the reporting quarter. It submits this report via the Contractor Reporting of Operational Workload Data (CROWD Form S) system no later than the 75th day following the close of the reporting quarter.

290.2 - Checking Reports

(Rev. 57, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

Before submitting Form S to CMS, the carrier checks for completeness and arithmetical accuracy. It uses the following checklist:

- Line 2 plus line 3 must equal line 1. *Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this will no longer be applicable.*
- Line 5 plus line 6 must equal line 4. Line 2 plus line 3 must equal line 1. *Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this will no longer be applicable.*
- Line 8 must be less than or equal to line 7.
- Line 9 must be greater than or equal to line 7.
- Line 10 must be less than or equal to line 9.
- Line 13 plus line 14 plus line 15 must be less than or equal to line 12.
- Line 16 must be greater than or equal to line 12.
- Line 17 must be less than or equal to line 16.
- Sum of lines 19-30, column 1 must equal line 10.
- Sum of lines 19-30, column 2 must equal line 17.

290.3 - Current Quarter Payments

(Rev. 57, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

The carrier reports in lines 1-3 the number of physicians receiving incentive payment checks during the current reporting quarter and in lines 4-6 the respective amounts of payment issued.

Physicians Receiving Checks

Line 1. Total Physicians - total number of physicians receiving incentive payments.

Line 2. Urban HPSAs - number of physicians receiving incentive payments classified as providing services in a HPSA urban setting. *Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this line must no longer be entered.*

Line 3. Rural HPSAs - number of physicians receiving incentive payments classified as providing services in a HPSA rural setting. *Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this line must no longer be entered.*

Amount Of Incentive Payments

Line 4. Total Incentive Payments - total amount of incentive payments issued to physicians.

Line 5. Urban HPSAs - amount of incentive payments issued to physicians for services provided in a HPSA urban setting. *Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this line must no longer be entered.*

Line 6. Rural HPSAs - amount of incentive payments issued to physicians for services provided in a HPSA rural setting. *Effective with the first quarterly report of 2005, that is due no later than 75 days after the close of the first calendar quarter of 2005, this line must no longer be entered.*

290.6 - Error Descriptions

(Rev. 57, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

This report breaks down the number of claims found to be paid incorrectly by selected error categories for "Current Quarter Reviews" and "Prior Quarter(s) Reviews". Claims counts reported in lines 19-30 under the "Number of Claims Current Quarter" column should total to the number reported in line 10. Similarly, claims counts reported in lines 19-30 under the "Number of Claims Prior Quarter(s)" column should total to the number reported in line 17. In a case where the claim could fall into more than one category, the

carrier makes a determination as to which category to put the claim in. Each claim incorrectly receiving a HPSA incentive payment should be counted only once under the "Error Descriptions" section.

Line 19. Office In, Service Outside HPSA - number of claims where the provider's office is located in a HPSA, but the provider travels to a non-HPSA to provide services.
Line 20. Office Outside, Service Outside HPSA - number of claims where neither the provider's office nor the place of service is located in a HPSA.

Line 21. Multiple Offices, Service Non-HPSA Office - number of claims when the physicians with multiple offices (some of which may be in a HPSA, and some of which are not) bill for services provided in their non-HPSA office.

Line 22. Beneficiary in HPSA, Services Outside HPSA - number of claims where the provider used the beneficiary's address for HPSA incentive eligibility instead of the place of service.

Line 23. Provider Codes Prior to Effective Date HPSA - number of claims where the services were provided before the effective date the area was designated as a HPSA. The effective date providers can begin coding claims for HPSA incentive payments is the first day of the second month following the date CMS is notified by PHS. CMS will transmit the effective date to the carrier. *Effective January 1, 2005, the effective date of a HPSA designation will be the date of the HRSA designation letter which will be reflected on the HRSA Web site.*

Line 24. Service Area No Longer HPSA - number of claims requesting HPSA payment after the area is no longer classified as a HPSA. CMS will transmit the termination date to the carrier.

Line 25. Non-Physician Practitioner - number of claims coded for HPSA incentives, but the services were provided by someone other than a physician. An example is a claim submitted with the HPSA modifier, and the service was provided by a nurse practitioner.

Line 26. Non-Physician Service - number of claims coded for HPSA incentives which were for services other than physician professional services. Examples of services furnished by a physician, but not subject to the HPSA incentive, are technical components of diagnostic tests, drugs, and separately payable supplies.

Line 27. Carrier Provided Incorrect Information - number of claims that were incorrectly coded by the provider for HPSA incentives as a result of incorrect information the carrier provided.

Line 28. Carrier Published Incorrect Notice - number of claims where the provider code for HPSA incentives was based on a population group (noncovered) HPSA notice the carrier incorrectly published.

Line 29. Carrier Keying/Processing Error - number of claims paid for the HPSA incentives inappropriately due to keying or processing errors made by carrier staff.

Line 30. Other - number of claims that do not fit into any of the other categories. Although not routinely required, carriers may be asked to expand on the reason for error on these types of claims.